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Health care **users' perception** of the **quality of ART services** in selected health facilities in Gaza, Inhambane, Maputo, and Zambézia provinces

Results of the first cycle of community-led monitoring

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1. INTRODUCTION

N'weti's community HIV service provision program in Gaza, Inhambane and Zambézia provinces has identified a number of factors negatively affecting the perception of people living with HIV (PLHIV) of the quality of ART services such as breaches in confidentiality, low awareness of rights of PLHIV among the frontline service providers, long waiting times, illicit charges, stock-outs antiretrovirals (ARV), etc., that ultimately may result in lower retention in care and treatment. To address these barriers, N'weti implements a community-led monitoring (CLM) activity, using the community scorecard (CSC) tool that enables local communities, particularly PLHIV, to engage with frontline health service providers to improve the quality and access to ART services in a multistep cycle from mobilization to joint planning and advocacy.

The World Bank (2005) understands the CSC process as a combined participatory tracking of service performance (i.e. 'input tracking'), service providers' self-evaluation, and community interface meetings, in which performance assessments are discussed and remedial action plans developed. The CSC process uses the collective as its unit of analysis, and is focused on monitoring at the local/facility levels. It facilitates community monitoring and performance evaluation of services. The CSC process uses information generated by scoring and qualitative information collected through focus group discussions. It relies heavily on the participation of community members in the assessment of service quality and performance, and on them negotiating the findings with service providers (Babajanian, 2014).

N'weti engages PLHIV to monitor the quality of services they receive in 75 targeted health facilities (HF) previously agreed with USAID. By engaging PLHIV, N'weti aims to promote constructive dialogue between frontline service providers and service users towards improved ART services. Most importantly, during the process PLHIV identify and score dimensions that affect their perception of quality and access to effective ART service delivery. This document summarizes the approach used by N'weti in implementing the CLM of ART services from the user's perspective during FY21 and provides the results of the first scoring cycle of the CLM activity.

2. METHODOLOGY

2.1. Detailed steps of PLHIV-led monitoring

The CLM process starts with mobilization, during which preliminary mapping and community mobilization is undertaken in the catchment area of each HF. This step includes mapping of the services offered by each HF to be assessed and collection of other relevant data such as health services offered by the HF, mapping of the co-management and humanization committees (Comités de co-Gestão e Humanização, CcGH), health committees and ART committees. At this preparatory stage, the CLM approach and its aims are presented to district health authorities (Serviço Distrital de Saúde, Mulher e Acção Social (SDSMAS)), HF management and service providers, as well as to community-based structures.

Community groups of PLHIV who are voluntarily willing to engage in the CLM activity are trained on the CLM process and a set of indicators is discussed and agreed with them. These indicators are scored separately by groups consisting of PLHIV/HIV-affected families and by groups of health providers. PLHIV participating in the CLM activity are selected among the service users of the HFs that are assessed so that they can provide the user perspective on the services of that specific HF. Thus, both sides – service providers and service users – assess the quality of the ART services offered by the HF from their own perspectives.

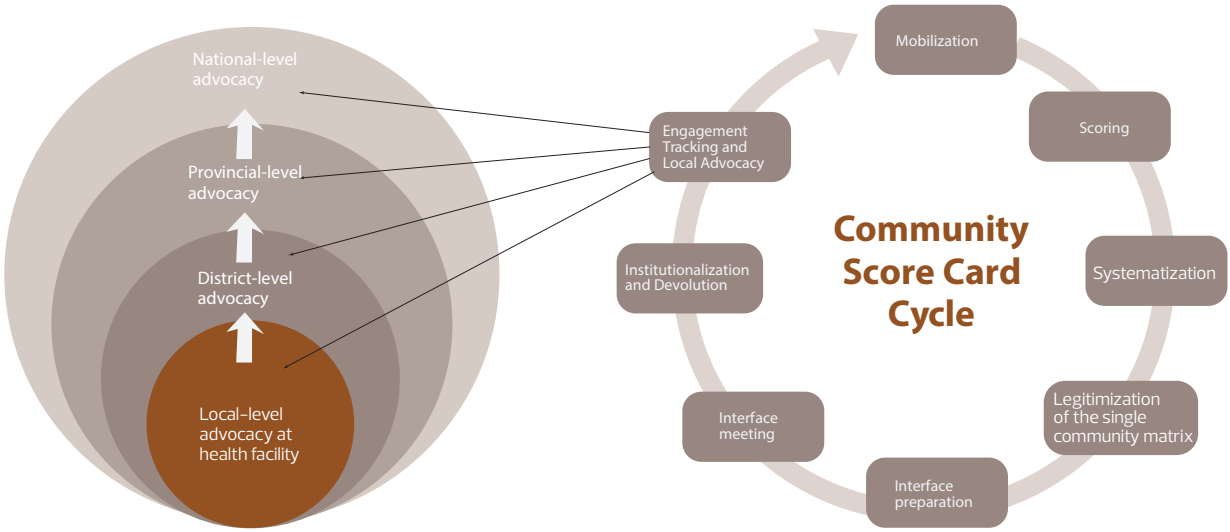
Our adapted methodology requires several groups of PLHIV in the HF catchment area to score the same set of indicators. The scores of the different PLHIV groups are then systematized in a single matrix which summarizes the results of the assessments and scores of the groups. This single matrix requires legitimization and validation by PLHIV before it is taken for an interface meeting with health providers at the HF level. Selected representatives of the group of PLHIV is trained by N'weti for the interface meeting with health providers, in order to improve their understanding on the issues raised by the community members and to strengthen their negotiations skills and ability to assertively manage confrontation, discrimination and any other possible negative outcome that might arise in the meeting. During the interface meeting, the selected community members and the providers come together to revisit their scores, concerns and to propose solutions until priority actions are agreed in a joint action plan. In each HF, the community engagement focal point assists with coordination of the activity at the HF level and leads the interface meeting between PLHIV and the ART committee, allowing for integration of agreed actions in the ART committee's plans.

Devolution of the agreed actions to a broader group of PLHIV is conducted through different retention platforms including the community adherence and support groups (Grupos de Apoio à Adesão Comunitária, GAACs) and other PLHIV support groups such as those facilitated by mentor mothers and peer educators. In coordination with

the community engagement focal point, clinical partners and HF management, agreed solutions from the CLM activity are added as agenda items of the ART committee for systematic review and follow-up of progress. Evidence from the CLM is used to inform planning processes at the HF level and shared with the clinical partners for joint follow-up. The action plan is monitored monthly by both PLHIV and health providers through existing mechanisms for community participation in the management of the HFs and through the ART committees.

The action plan is also discussed with the representatives of SDSMAS, National AIDS Council (NAC, Conselho Nacional de Combate ao SIDA, CNCS) and local leaders in order to seek buy-in for the identified solutions and for the action plan from decision makers at local and district levels. A CLM report with key challenges identified by PLHIV during scoring, agreed solutions including the action plan for the HF, is generated and shared with all concerned actors at district, provincial and central levels. Agreed actions from the interface meeting are also integrated in the planning and budgeting by the district health authorities. Priority solutions which require action beyond the HF scope, are scaled up by N'weti and the Mozambican civil society platform for health (Plataforma da Sociedade Civil para Saúde, PLASOC) for engagement and advocacy at provincial and central levels with the NAC and the National HIV Program (Programa Nacional de Controlo das ITS/HIV e SIDA, PNC ITS/HIV e SIDA). The diagram below summarizes the process described above.

Diagram 1 – N'weti's community-led monitoring cycle



During FY21, N'weti implements two cycles of the CLM approach engaging an estimated number of over 7,000 PLHIV or their caregivers/family members during each cycle. The first scoring cycle was a baseline. The second scoring cycle will be conducted at the same 75 HFs, with the same indicators and the same definition of the participants, enabling changes and progress to be identified between the two scoring cycles. Besides regular monitoring through the HF ART and co-management committees, PLHIV also monitor the implementation of agreed actions as they access the ART services. PLHIV score and monitor the key dimensions of ART service quality presented in table 1 below.

Table 1 – Key dimensions scored and monitored by PLHIV

Dimension	Indicators
ART services	Hygiene/cleanliness of the consultation room
	Privacy during the consultations
	Quality of care provided
	Differentiated service delivery (DSD) models
	Illicit charges
Psychosocial support (PSS) services	Quality of counselling during the first PSS consultation
	Quality of counselling on drug intake and side effects of ART
	Quality of information provided about serostatus disclosure and the support from the family, community and other PLHIV
Services at the pharmacy	ART availability
	Quality of counselling provided by the pharmacy technician about taking ART
Respect for rights of PLHIV	Courtesy of frontline services providers
	Knowledge about viral load

Key dimensions scored and monitored by PLHIV: ART services; Psychosocial support (PSS) services; Services at the pharmacy and, rights of PLHIV

2.2. Participant selection

Five (5) different types of groups consisting of PLHIV or their caregivers/family members are formed in the catchment area of each HF according to the categories below. Detailed criteria for exclusion and inclusion in the scoring groups are discussed with USAID, PLASOC, CNCS and clinical partners. The criteria defining the groups are not mutually exclusive, for example, due to the caregivers of children living with HIV often being HIV-positive themselves, the caregiver group can include adult women and men living with HIV and on ART. Each community group is composed of 10 to 12 members. A total of 15 participants for each group are mobilized to count for situations where some of the identified members might drop out. Participants are selected from existing community structures such as the GAACs, mother-to-mother support groups, and other community support groups. Clinical partners are engaged in each site throughout the CLM process. The use of specific criteria supports the selection of participants.

N'weti ensures that the rights of PLHIV, including confidentiality, is respected. The groups in each category are formed in each HF catchment area as shown in table 2 below, amounting to a total of 700 groups and about 7000 participants per scoring cycle. Groups are formed using purposive sampling and score the indicators based on the following metrics: Very good, Good, Bad, Very bad.

Table 2 – Group categories

Group category	No. of groups per HF
Adult women living with HIV on ART	2
Adult men living with HIV on ART	2
Young boys and young girls living with HIV on ART	2
Female and male caregivers of children living with HIV and affected family members	2
Pregnant and breastfeeding women who have received PMTCT* services	2
Total in 1 (one) HF	10

*Prevention of mother-to-child transmission

2.3. Geographic scope and timeline

Geographic scope of PLHIV-led monitoring

A total of 75 HFs in Gaza, Inhambane, Maputo and Zambézia provinces are engaged in the CLM activity as illustrated below in table 3. A detailed list of the selected HFs (all AJUDA sites) is provided in appendix 1.

A total of 75 HFs in Gaza, Inhambane, Maputo and Zambézia provinces are engaged in the CLM activity

Table 3 – Targeted health facilities

Province	District	PEPFAR-supported HFs	Total
Gaza	Chòkwé	15	15 HFs
Inhambane	Massinga	2	4 HFs
Inhambane	Maxixe	2	
Maputo province	Manhiça	11	13 HFs
Maputo province	Marracuene	2	
Zambézia	Alto Molócuè	2	43 HFs
Zambézia	Gurué	2	
Zambézia	Milange	11	
Zambézia	Mocuba	18	
Zambézia	Namacurra	10	

Timeline

N'weti implements two (2) cycles of the CLM approach during FY21. The first cycle of the CLM was implemented from October 2020 to March 2021, followed by advocacy activities from April 2021 until the end of FY21. The second cycle of the CLM will start in July 2021, followed by advocacy activities until the end of FY21. A detailed timeline with sub-activities for each phase of the CLM is shared for discussion with USAID and NAC as well as with clinical partners in the targeted provinces.

Due to the risks posed by COVID-19, N'weti ensures that safe spaces for the CLM are created in all sites to guarantee the reduction of exposure and vulnerability of participants to COVID-19. The preparatory meetings, scoring, interface and devolution meetings are done in open spaces. Social distancing, the use of protective masks and washing/disinfecting hands are enforced throughout the CLM process in alignment with the Ministry of Health's (MoH) COVID-19 preventive measures.

The CLM activity is financed by USAID, and implemented by N'weti in coordination with the clinical partners of CDC and the National AIDS Council (NAC)

2.4. Preparatory activities and data collection during the first cycle of community-led monitoring

Preparatory activities

The CLM activity is financed by USAID, and implemented by N'weti in coordination with the clinical partners of CDC and the National AIDS Council (NAC). The design of the process and development of tools for community consultations were done by N'weti, USAID's/CDC's technical staff and the clinical partners.

The selection of the HFs for the CLM activity considered the following criteria:

a) HFs that were included in the CLM activity regarding provision of primary care in 2019 by N'weti together with the MoH; and

b) HFs that are supported by the clinical partners financed by CDC.

The selection and training of district teams and the development of workplans was undertaken by N'weti, in coordination with the clinical partner, the provincial health directorate *(Direcção Provincial de Saúde, DPS) and the provincial health services (Servicos Provincias de Saude, SPS)*. The training was held in each selected district in February 2021.

The approval of the above-mentioned process took place in two stages. First, the CSC process, including the indicators and tools, was presented to the national level directorate of quality control in the national health system *(Direcção de Gestão de* Garantia da Qualidade, DGGQ) and to the D/SPS technical group in February 2021, with

the involvement of the clinical partner. This process was followed by recruitment and training of the field teams, after receiving the credentials to field work from the District Services for Health, Women and Social Action (*Serviços Distritais de Saúde, Mulher e Acção Social, SDSMAS)* of each district.

After this, N'weti initiated the formal introduction of the CLM implementation plan to the DPS and to the targeted districts, with support from the focal points appointed by the SDSMAS and clinical partners. In addition, N'weti and the focal points of the clinical partner presented the plans to the Provincial Secretaries and to the SDSMAS in each district. To ensure ownership of the plans at the provincial and district levels, whenever necessary, the teams revised the plans. This contributed to the involvement and participation of SDSMAS technicians in the training and in the first scoring session.

The involvement of the representatives of clinical partners in the trainings aimed to ensure that they were familiar with the field teams and the activity plans and, on the other hand, to establish a recruitment process of eligible participants. The coordination with the clinical partner, and the provincial and district directorates of health, allowed for greater collaboration in the recruitment and mobilization of participants through different HF services as well as through the community workers (such as activists) of the clinical partner. Participants were also identified through other interventions, such as support groups and differentiated service delivery (DSD) models that are managed by the clinical partner.

Data collection

The CLM activity to monitor the quality of health services was undertaken with the CSC tool. CSC is a tool that allows the users of public health services to participate, in an active and organized manner, in the monitoring of the quality of services provided by HFs. Thus, the methodological approach for the implementation of this exercise considered at all stages of the cycle qualitative and participative data collection and analysis techniques.

Document review

The document review under this activity was not exhaustive, and included only some documents that helped the team to understand the nature of the services provided by the target HFs, with an emphasis on the routine plans and statistics regarding the provision of HIV services. By reviewing the plans and statistics, the team collected information on the type of each target HF, as well as the nature of the HIV and ART services provided by the HF, thereby enabling the design and adjustment of the training plans. This HF data showed, for example, that some targeted HFs do not have enough health providers to respond to the needs in terms of ART services.

Focus group discussions

The focus group discussions (FGD) were defined as debates in groups consisting of 8 to 12 people and conducted by a pair of facilitators. During the FGDs, the group members could speak freely and spontaneously about the topic under discussion. For the CLM activity, the discussions formed a valuable qualitative tool to catch the users' and providers' thoughts and perceptions on the quality of ART services provided in the selected HFs. The FGDs were implemented for the following target groups:

a) Adult women living with HIV and on ART;

b) Adult men living with HIV and on ART;

c) Young boys and young girls living with HIV and on ART;

d) Female and male caregivers of children living with HIV and affected family members;

e) Pregnant and breastfeeding women on PMTCT; and

f) Providers at the HF.

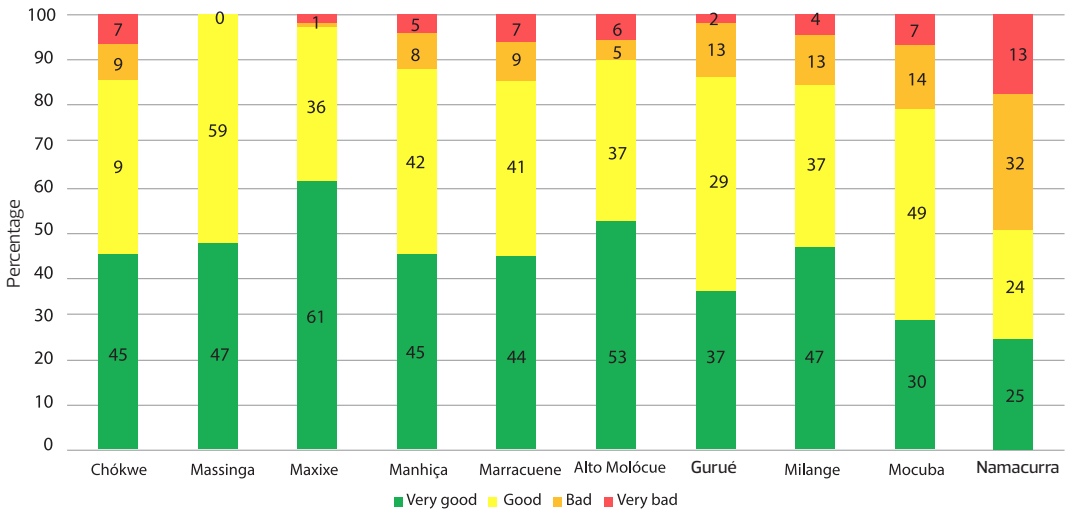
3. RESULTS OF THE FIRST ROUND OF COMMUNITY-LED MONITORING

3.1. Quality of ART services

Under this dimension, the following indicators were scored: (a) hygiene in the consultation rooms for chronic diseases; (b) privacy in the consultation room for PLHIV; (c) care provided during consultations for PLHIV; (d) DSD models and, (e) illicit charges.

In general, the users' perception of hygiene in the consultation rooms for chronic diseases in ART services is positive (chart 1). Massinga ("Good" = 53% and "Very good" = 47%), Maxixe ("Good" = 36% and "Very good" = 61%) and Alto Molócuè ("Good" = 37% and "Very good" = 53%) had the best results in this indicator, while Namacurra is the only district with a high percentage of dissatisfaction: "Bad" (32%) and "Very bad" (18%). The reason behind this result might be poor cleaning due to lack of cleaning material and, as a result, the consultation rooms and the toilets are dirty. There is also a need to recruit cleaners who can ensure the cleanliness of the consultation rooms and toilets.

Chart 1: How do you evaluate the level of hygiene in the consultation rooms for chronic diseases?



Under this dimension, the following indicators were scored: (a) hygiene in the consultation rooms for chronic diseases; (b) privacy in the consultation room for PLHIV; (c) care provided during consultations for PLHIV; (d) DSD models and, (e) illicit charges.

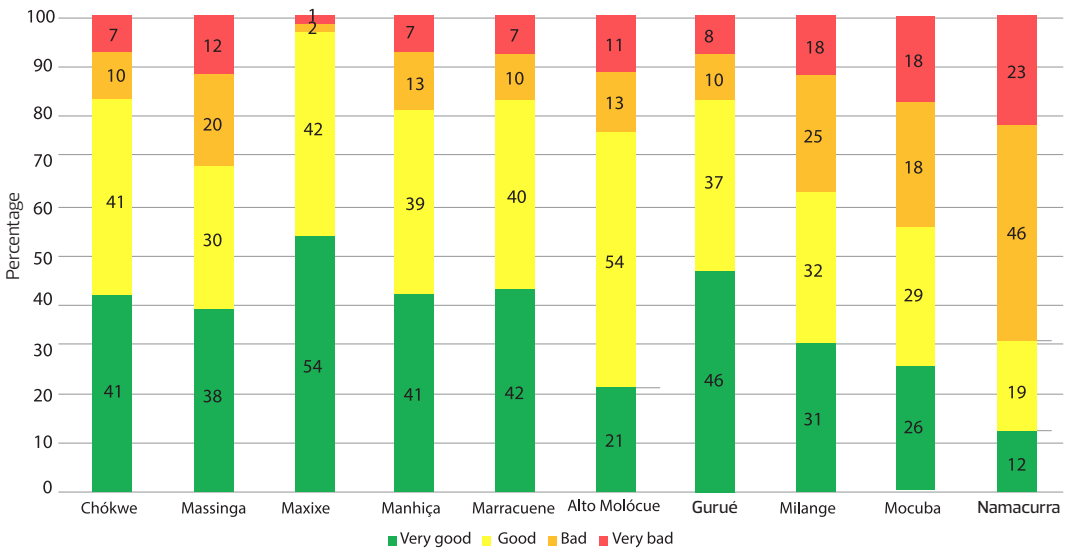
"In the room where we are treated, they attend to more than one patient. Sometimes we are two people at the same time, only separated by a curtain." (Adult man living with HIV and on ART – Malei health center (HC), Namacurra district)

As can be seen in chart 2 below, Maxixe had the best result in the indicator regarding the privacy of the consultation room ("Good" = 42% and "Very good" = 54%). Chókwè district had the second-best result ("Good" = 41% and "Very good" 41%), despite a considerable number of dissatisfied users (the total of "Bad" and "Very bad" corresponding to 17%), while Marracuene district had an almost identical result to that of Chókwè. Namacurra district had again the worst result ("Bad" = 46% and "Very bad" = 23%). The districts of Mocuba ("Bad" = 26% and "Very bad" = 18%) and Milange ("Bad" = 25% and "Very bad" = 13%) had a high level of user dissatisfaction, despite over 50% of users having a positive perception about the privacy of the consultation room in both of these districts. The results of Mocuba and Milange districts, and others with similar results point to the need to intensify trainings for the health providers regarding their responsibilities and users' rights, and to the necessity to invest in the infrastructure to enable separate physical spaces for different simultaneous activities in order to guarantee privacy. One of the participants referred to this need in his comment:

> "In the room where we are treated, they attend to more than one patient. Sometimes we are two people at the same time, only separated by a curtain." (Adult man living with HIV and on ART – Malei health center (HC), Namacurra district)

Statements like this were frequent and presented at several CLM sites, reflecting major difficulties of the providers to comply with the basic protocols of service provision. These include the right to privacy, which is one of the fundamental rights of the health service user, especially in the context of a chronic disease that still has a strong stigma attached to it.

Chart 2: How do you evaluate the privacy of the consultation room for PLHIV?



More than half of the users perceived the quality of care provided by health providers during the consultations for PLHIV satisfactory (chart 3). The districts of Massinga ("Good" = 44% and "Very good" = 54%), Maxixe ("Good" = 45% and "Very good" = 50%) and Alto Molócuè ("Good" = 24% and "Very good" = 67%) had the best results, with less than 10% of the users having a negative perception. In the opposite extreme we find the districts of Gurué ("Bad" = 21% and "Very bad" = 25%), Namacurra ("Bad" = 17% and "Very bad" = 16%) and Mocuba ("Bad = 16% and "Very bad" = 10%), all with considerable percentages of community members whose perception of the quality of care provided during the consultations for PLHIV was negative. The HFs that had negative results deserve urgent attention. For example, the statements presented during the CSC process reveal that some PLHIV do not feel properly cared for, as expressed in the two statements below:

> "They don't take enough time for counselling. It feels like they just want to get rid of us." (Pregnant woman on PMTCT – Maxixe HC, Maxixe district)

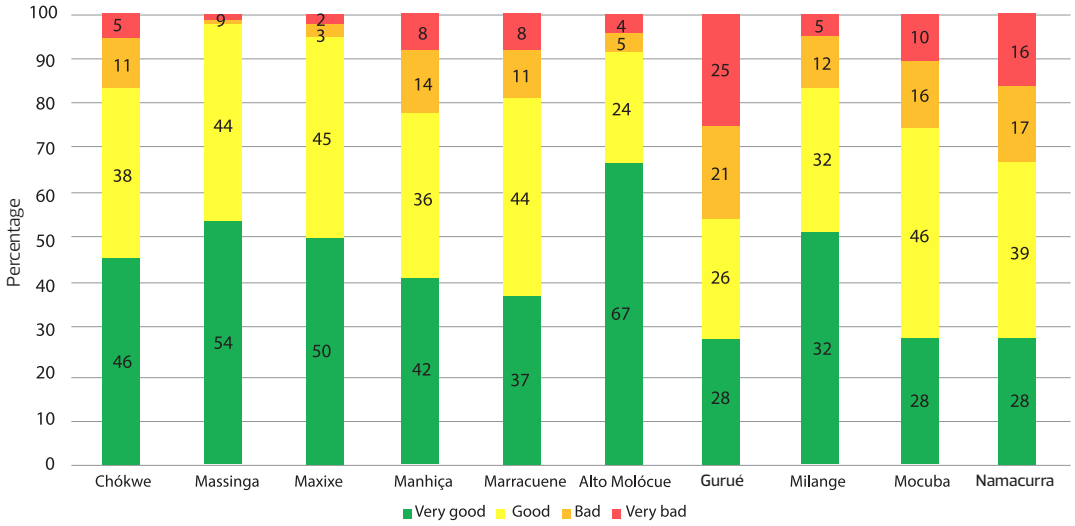
> "The providers serve with no empathy; to overcome this situation, there should be more empathy, they must be more attentive." (Pregnant woman on PMTCT – Taninga HC, Manhiça district)

One reason for the complaints about the quality of care could be the fact that, due to the high work load of the providers, they try to shorten the consultation times as a strategy to reduce the waiting times. Also, the constant changes of health providers are mentioned as one of the factors behind the long queues. Although the majority of the patients understand these difficulties, almost all of them consider intolerable the situations when the provider gives priority to personal issues, like speaking on the phone, instead of attending to the patients' health concerns. The following excerpt reflects this type of dissatisfaction:

> "Delays in care, they use too much time on the phone. They attend to people who jump the queue." (Adult man living with HIV and on ART -Maragra HC, Manhiça district)

One reason for the complaints about the quality of care could be the fact that, due to the high work load of the providers, they try to shorten the consultation times as a strategy to reduce the waiting times.

Chart 3: How do you evaluate the quality of care provided by health providers during the consultations for PLHIV?



Although the majority of the patients understand these difficulties, almost all of them consider intolerable the situations when the provider gives priority to personal issues, like speaking on the phone, instead of attending to the patients' health concerns.

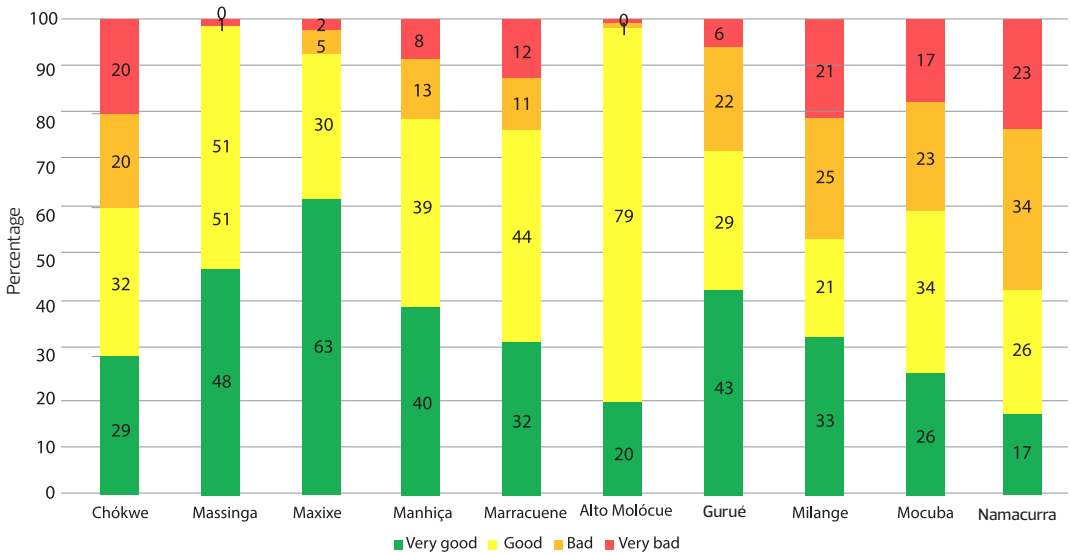
The family approach, one of the DSD models, is covered by the indicator which asks the users about the dispensing of ARV medications for the entire family on the same day. As shown by chart 4 below, there are challenges related to this approach that need attention. With the exception of Alto Molócuè ("Good" = 79% and "Very good" = 20%), Massinga ("Good" = 51% and "Very good" = 48%) and Maxixe ("Good" = 30% and "Very good" = 63%), the remaining districts had considerable levels of dissatisfaction. Again, the district of Namacurra ("Bad" = 34% and "Very bad" = 23%) has the worst results, followed by Milange ("Bad" = 25% and "Very bad" = 21%), Chókwè ("Bad" = 20% and "Very bad" = 20%), Mocuba ("Bad" = 23% and "Very bad" = 17%) Gurué ("Bad" = 22% and "Very bad" = 6%) and Marracuene ("Bad" = 11% and "Very bad" = 12%).

Some of the reasons behind the negative perception of this approach include the consequences of the entire family going to the HF and spending a long time there due to the long queues and waiting times. This means a pause in their livelihood activities, and leaves their houses and goods unprotected, susceptible to vandalism and theft. The statements below express this kind of insecurity:

> "It is bad! Because everyone goes out on the same day and consequently it compromises the individual and community activities." (Adult man living with HIV and on ART –Malei HC, Namacurra district)

> "The patients feel exposed to go all on the same day to the HF. In the community, when they see all of them, they will always ask." (Adult woman living with HIV and on ART – Muceliua HC, Namacurra district)

Chart 4: How do you feel when the entire family goes to pick up ART on the same day (family approach)?



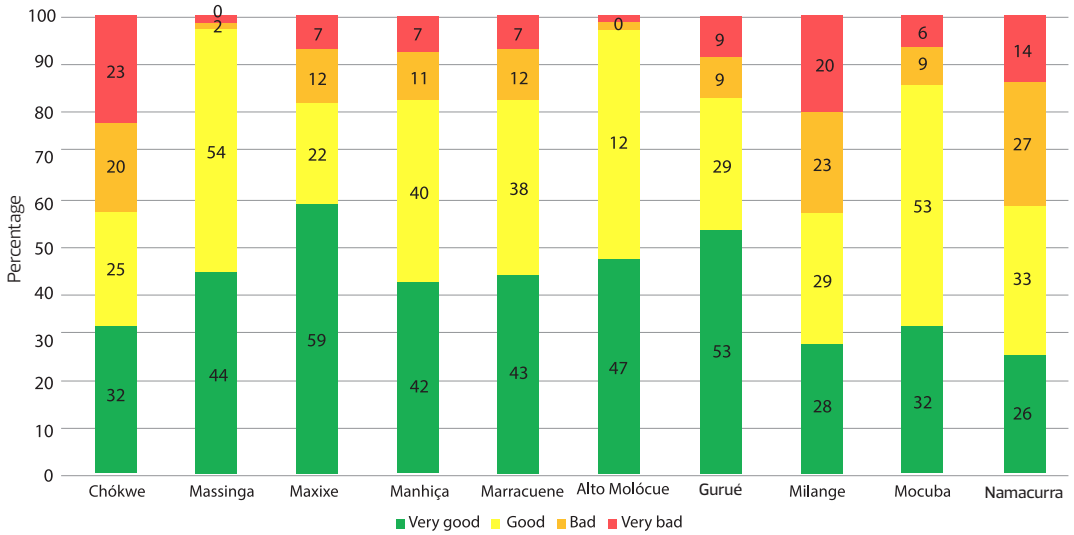
When the users were asked about the possibility to pick up ART directly from the pharmacy, without having to attend a consultation, the positive and negative perceptions follow the same pattern at district level (chart 5) as in the previous indicator. In the districts of Alto Molócuè ("Good" = 50% and "Very good" = 47%) and Massinga ("Good" = 54% and "Very good" = 44%), the users considered as effective the possibility of receiving ARV medication at the pharmacy without the need to see a health provider. Also the users in the districts of Mocuba ("Good" = 53% and "Very good" = 32%), Gurué ("Good" = 29% and "Very good" = 53%) and Manhiça ("Good" = 40% and "Very good" = 42%) had mainly positive answers. In contrast, Namacurra ("Bad" = 27% and "Very bad" = 14%), Milange ("Bad" = 23% and "Very bad" = 20%) and Chókwè ("Bad" = 20% and "Very bad" = 20%) have a high percentage of negative perceptions. This dissatisfaction can have different reasons, including the following: (a) the model reduces the frequency of contact with the providers; (b) some patients want to have consultations to clarify any doubts they might have, e.g. about the side effects of ART; and (c) the model makes it difficult to change the treatment line because this is not possible without a consultation. The two quotes below reflect some of these perceptions:

> "It is not good to go and get medication directly at the pharmacy without consultation, because the patient has gaps in knowledge about taking ARV medicines correctly." (Adult man living with HIV and on ART – Malei HC, Namacurra district)

"It is not good to go and get medication directly at the pharmacy without consultation, because the patient has gaps in knowledge about taking ARV medicines correctly."

"It is always necessary to have the consultation. What if the medication causes side effects? And there is no psychosocial support counselor at the pharmacy to provide guidance to the patients" (Adult woman living with HIV and on ART – Mutange HC, Namacurra district)

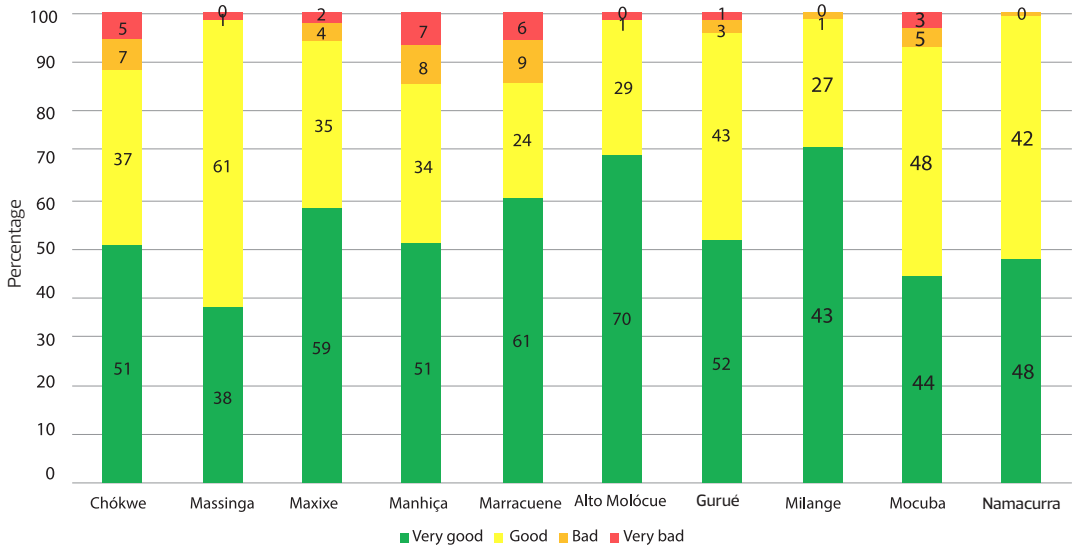
Chart 5: What do you think about the possibility to pick up ART directly from the pharmacy, without having to attend a consultation (fast-track ART refill)?



"It is always necessary to have the consultation. What if the medication causes side effects? And there is no psychosocial support counselor at the pharmacy to provide guidance to the patients"

The overall picture on the possible illicit charges required to be paid in the context of provision of ART is mostly positive, i.e. most users have not felt pressure to pay such fees as shown in chart 6 below. However, there are cases that need the attention of the local mechanisms of community participation, namely the CcGH, as well as the attention of the providers. The data show the existence of pressure to pay illicit charges in order to receive ART. The HFs in Marracuene ("Bad" = 9% and "Very bad" = 6%), Manhiça ("Bad" = 8% and "Very bad" = 7%), Chókwè ("Bad" = 7% and "Very bad" = 5%) and Mocuba ("Bad" = 5% and "Very bad" = 3%) districts are the ones most in need of an intervention to prevent illicit charges. This could be done through strengthening of the CcGHs, or by fully implementing the National Strategy to Prevent and Respond to Illegal Charges *(Estratégia Nacional de Prevenção e Combate às Cobranças Ilícitas)* 2017-2023 (MISAU, 2017). Illegal charges are an important barrier to access to health services, which also increase inequities in health.

Chart 6: Did you feel pressured to pay in order to receive ART?



The CLM activity sought information on user's perception and knowledge of DSD models. Charts 4 and 5 above describe indicators related to DSD models. In addition, the groups were asked to list the DSD models which the members could identify without mentioning the models. Percentages were calculated at overall and provincial level in terms of how many groups out of the total number of groups mentioned each specific DSD model.

Overall, when looking at all the groups in all provinces together, by far the best known DSD model is three-month scripting which was mentioned by 57% of all groups, followed by family approach (26% of the groups), and fast-track refills (23%). All the other models were mentioned by less than 10% of the groups, while 19% of the groups were not able to identify any DSD model.

Chart 7 below captures information about the knowledge of the users on different DSD models by province. When looking at the data at provincial level, in Zambézia province, 43% of the groups did not identify any DSD model, while 34% of the groups mentioned three-month scripting of ART, 33% identified the family approach, 8% mentioned the fast-track refills, 6% the one-stop model at the HF, 3% referred to the adherence clubs and 2% to the one-stop at the youth-friendly health services (YFHS, *Serviços Amigos dos Adolescentes e Jovens, SAAJ)*. In Gaza province, 86% of the groups identified three-month scripting of ART, 33% monthly scripting, 9% of the groups did not identify any DSD model, 6% referred to six-month scripting, 3% mentioned the one-stop model at the HF, 2% identified the family approach, as well as the weekly scripting. In Inhambane

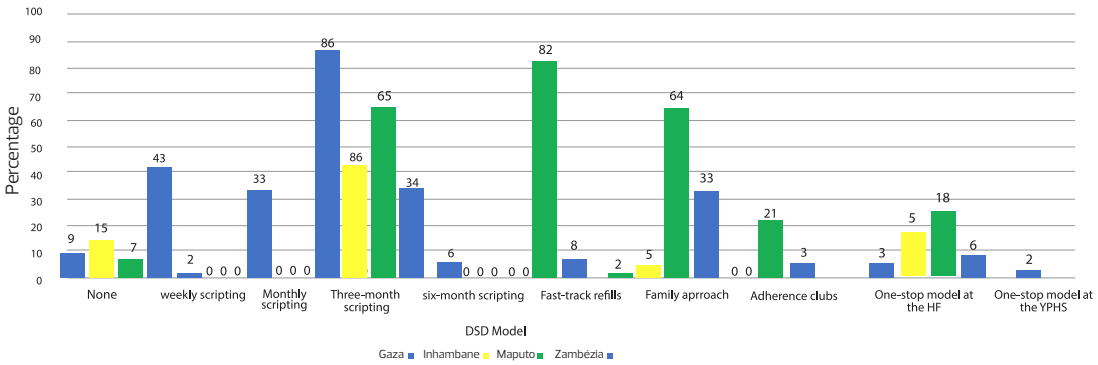
The overall picture on the possible illicit charges required to be paid in the context of provision of ART is mostly positive, i.e. most users have not felt pressure to pay such fees.

province, 43% of the groups identified three-month scripting of ART, 15% of the groups did not mention any type of DSD model, 5% mentioned the family approach, as well as the one-stop model at the HF. In Maputo province, 82% mentioned the fast-track refills, 65% identified three-month scripting of ART, 64% mentioned the family approach, 21% referred to the adherence clubs, 18% mentioned the one-stop model at the HF and 7% of the groups did not identify any type of DSD model.

In Maputo province, 82% mentioned the fast-track refills, 65% identified three-month scripting of ART, 64% mentioned the family approach, 21% referred to the adherence clubs, 18% mentioned the one-stop model at the HF and 7% of the groups did not identify any type of DSD model.

The data show major variations between provinces in knowledge of different DSD models. This can be explained by differences in the intensity of implementation of the different DSD models between clinical partners, and even between different districts or HFs supported by the same clinical partner. However, what is alarming that almost one-fifth of the groups were not able to name any DSD models, pointing to the need to raise awareness of PLHIV on these models that can potentially improve retention in care and treatment. When charts 4, 5 and 7 are compared, it can be noted that some districts in provinces with high level of knowledge of a certain DSD model, have negative perceptions of the same model. The reasons for this will be studied in more depth during the second cycle of the CLM activity.

Chart 7: Percentage of groups that mentioned DSD models, by type of DSD model and province



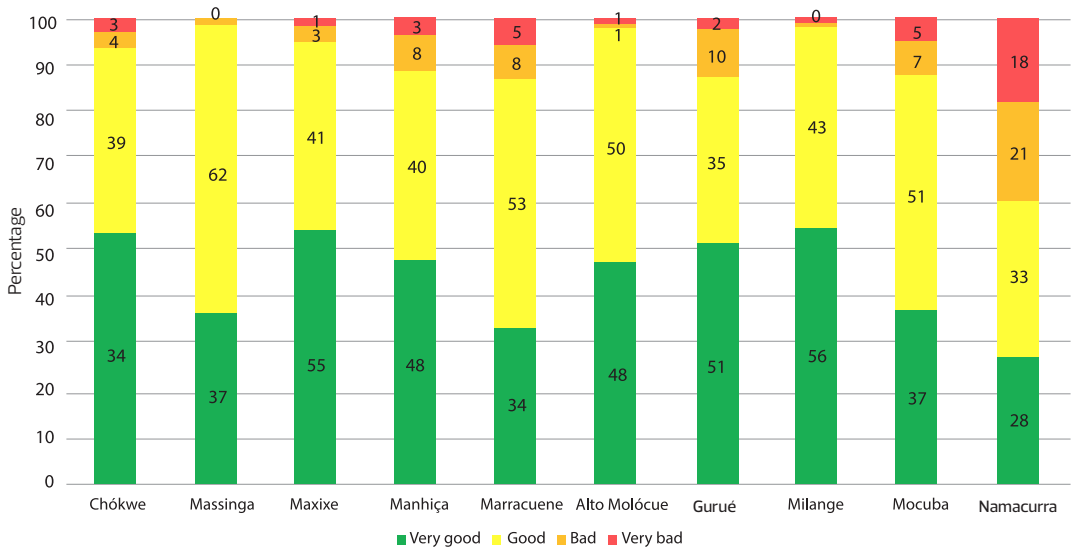
3.2. Quality of the psychosocial support (PSS) services

Three indicators regarding PSS services were scored, about (a) counselling offered during the first PSS consultation, (b) information provided about taking ART and its side-effects and, (c) information provided about serostatus disclosure and the support from the family, community and other PLHIV.

The indicator about counselling provided during the first PSS consultation (chart 8) had a mostly positive result, especially in the districts of Massinga ("Good" = 62% and "Very good" = 37%), Milange ("Good" = 43% and "Very good" = 56%) and Alto Molócuè ("Good" = 50% and "Very good" = 48%). Also the districts of Maxixe ("Good" = 41% and "Very good" = 55%) and Chókwè ("Good" = 39% and "Very good" = 54%) had mostly positive results. As in the other indicators, Namacurra district had the clearly highest level of dissatisfaction, with 21% and 18% of participants scoring this indicator as "Bad" and "Very bad", respectively.

The indicator about counselling provided during the first PSS consultation had a mostly positive result, especially in the districts of Massinga, Milange, and Alto Molócuè;

Chart 8: How do you evaluate the counselling provided during the first PSS consultation?



A similar pattern of results as in the previous indicator, is observed in the indicator regarding the quality of information provided during PSS consultation about taking ART and its side effects (chart 9). The overall perception is positive with again Massinga, Alto Molócuè and Milange having the best results. In Namacurra, about half of the users of the PSS services had a negative perception, with 25% scoring the information provided as "Bad" and 21% as "Very bad". Gurué ("Bad" = 7% and "Very bad" = 12%), Manhiça ("Bad" = 10% and "Very bad" = 6%) and Marracuene ("Bad" = 9% and "Very bad" = 7%)

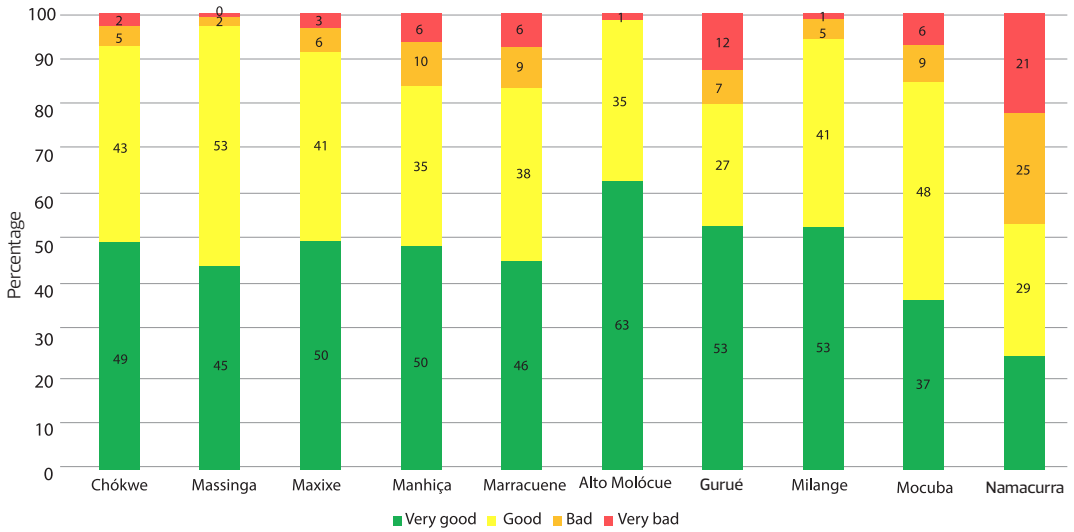
had a lower but significant level of dissatisfaction. The consultation time is considered short by the community members, and this is reflected in the negative perceptions on this indicator. Comments recorded during the focus group discussion highlight, not only the need of attention, as described above, but also more time of interaction with the provider:

> ''The providers do not have the time to clarify the doubts that we have'' (Pregnant or breastfeeding woman on PMTCT – Muceliua HC, Namacurra district)

> ''The health providers should speak the local language, because there are things that we do not understand in Portuguese'' (Adult woman living with HIV and on ART – Mbaua HC, Namacurra district)

''The health providers should speak the local language, because there are things that we do not understand in Portuguese''

Chart 9: How do you evaluate the information provided during PSS consultation about taking ART and its side effects?



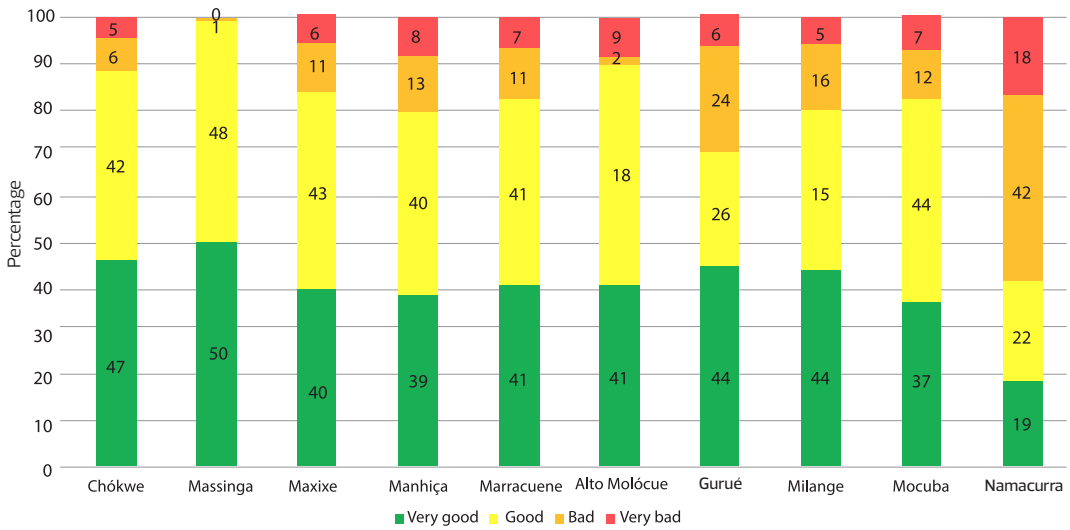
In the indicator regarding the quality of information provided about serostatus disclosure and the support from the family, community and other PLHIV (chart 10), the district of Namacurra, again, has the worst results. Of the users of the HFs of this district, 22%, 19%, 42% and 18% scored this indicator as ''Good'', ''Very good'', ''Bad'' and ''Very bad'', respectively. Many users in the districts of Gurué (''Bad'' = 24% and ''Very bad'' = 6%), Milange (''Bad'' = 16% and ''Very bad'' = 5%), Manhiça (''Bad'' = 13% and ''Very bad'' = 8%), Mocuba (''Bad'' = 12% and ''Very bad'' = 7%), Marracuene (''Bad'' = 11% and ''Very bad''= 7%) and Maxixe (''Bad'' = 11% and ''Very bad'' = 6%) were also dissatisfied with this service. In line with the good performance in other indicators reported above, Massinga (''Good'' = 48% and ''Very good'' = 50%) had clearly the best results also in this indicator.

In addition to lack of information, stigma and discrimination in the family and community contexts can impede serostatus disclosure. The two quotes below reveal the dilemma that PLHIV experience: they recognize the importance of serostatus disclosure as a way to receive more support, yet they fear that after revelation, stigma hinders them to live with dignity.

> "The idea of serostatus disclosure is good to get some support, but there is a lot of discrimination in the community." (Caregiver of children living with HIV or an affected family member – Macuse HC, Namacurra district)

> "It really is better not to disclose one's serostatus, because there is discrimination, even in our family." (A young boy living with HIV and on ART – Muceliua HC, Namacurra district)

Chart 10: How do you evaluate the information provided about serostatus disclosure and the support from the family, community and other PLHIV?



Two indicators related to the services at the pharmacy of the HFs were used, namely, indicators on the (a) availability of ARV medicines and, (b) information provided by the pharmacy technician about taking ART.

3.3. Quality of the services at the pharmacy

Two indicators related to the services at the pharmacy of the HFs were used, namely, indicators on the (a) availability of ARV medicines and, (b) information provided by the pharmacy technician about taking ART (chart 11). The first indicator gathered overall positive responses. Massinga district had an excellent performance also in this indicator, with 49% and 50% of users scoring this dimension as "Good" and "Very good", respectively. Maxixe had the highest score of "Very good" (86%), while 11% chose the

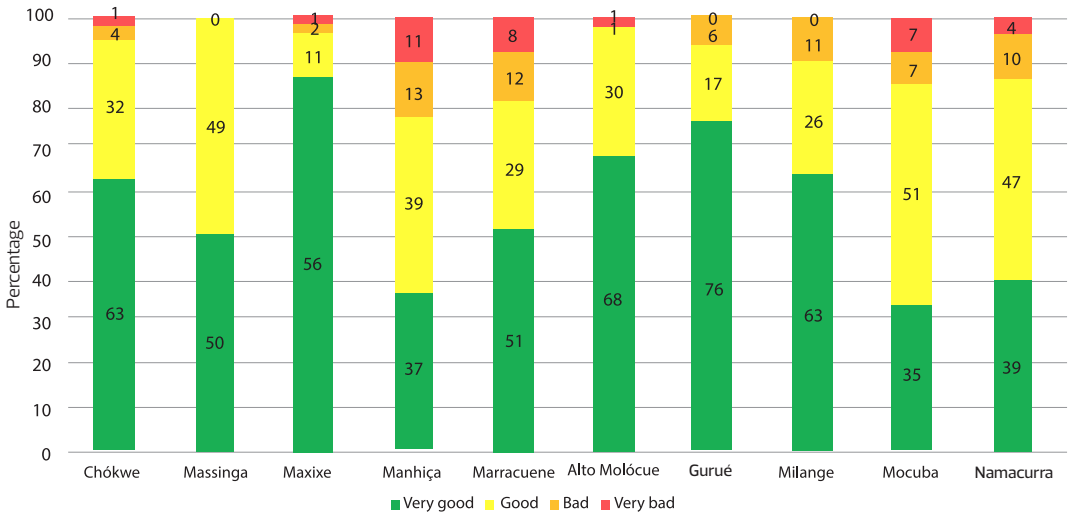
option "Good". Also Alto Molócuè had excellent results with 68% and 30% scoring the availability of ART as "Good" and "Very good", respectively.

Manhiça ("Bad" = 13% and "Very bad" = 11%), Marracuene ("Bad" = 12% and "Very bad" = 8%), Namacurra ("Bad" = 10% and "Very bad" = 4%) and Mocuba ("Bad" = 7% and "Very bad" = 7%) deserve special attention due to the highest percentages of dissatisfaction with the availability of ART. In some occasions stockouts occur and the users are requested to return to the pharmacy later on:

> "Sometimes they ask us to return the following day due to the lack of medicines on the day of consultation." (A young girl living with HIV and on ART – HC Nhaluanda, Mocuba district)

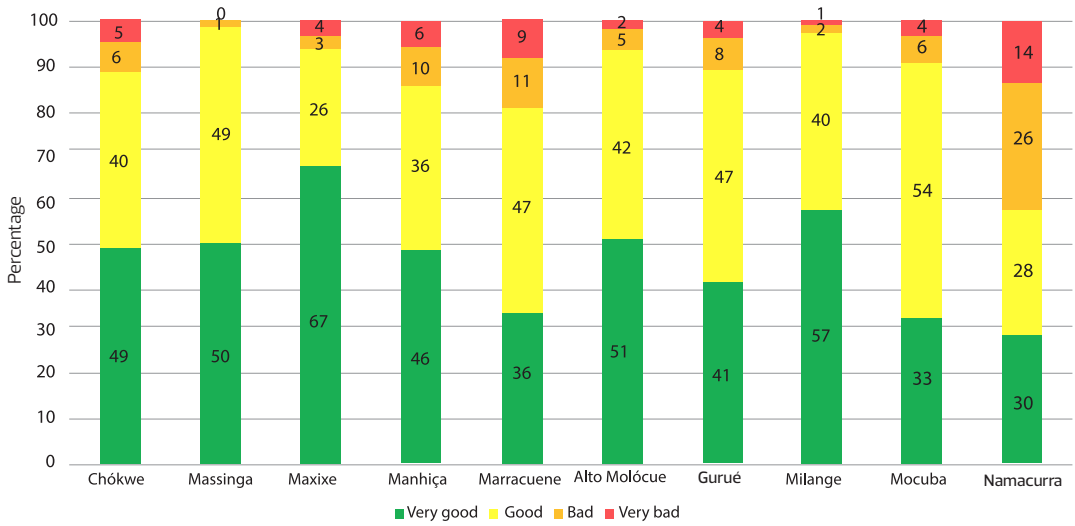
Some of the comments reveal that the language used constitutes a considerable barrier, since most of the pharmacy technicians communicate in Portuguese instead of the local languages.

Chart 11: How would you evaluate the availability of ARV medicines in the pharmacy of the HF when you needed to collect them?



Most districts had satisfactory performance in terms of the quality of information provided by the pharmacy technician about taking ART (chart 12). However, Namacurra has problems also in this dimension ("Bad" = 28% and "Very bad" = 14%), followed by Marracuene ("Bad" = 11% and "Very bad" = 9%) and Manhiça ("Bad" = 10% and "Very bad" = 6%). Some of the comments reveal that the language used constitutes a considerable barrier, since most of the pharmacy technicians communicate in Portuguese instead of the local languages.

Chart 12: How do you evaluate the information provided by the pharmacy technician about taking ARV medicines?



3.4. Respect for the rights of PLHIV

This dimension has two indicators: (i) the way the PLHIV are treated at the HF, and (ii) the level of knowledge about viral load. Massinga ("Good" = 57% and "Very good" = 41%) and Maxixe ("Good" = 43% and "Very good" = 55%) had clearly the best results in terms of the way PLHIV were treated at the HF, with only 2% of users expressing dissatisfaction in each district (chart 13). In the other end, Namacurra scored again negatively ("Bad" = 27% and "Very bad" = 15%). However, there was clear dissatisfaction also in other districts, and 20% or above of users in Alto Molocué (which in many previous indicators scored positively), Manhiça and Marracuene scored the treatment of PLHIV as either "Bad" or "Very bad". For Chókwè and Milange the corresponding percentages were 17 and 16, respectively. These high percentages are a cause of great concern and point to the need to train the health providers on the importance of treating the patients well.

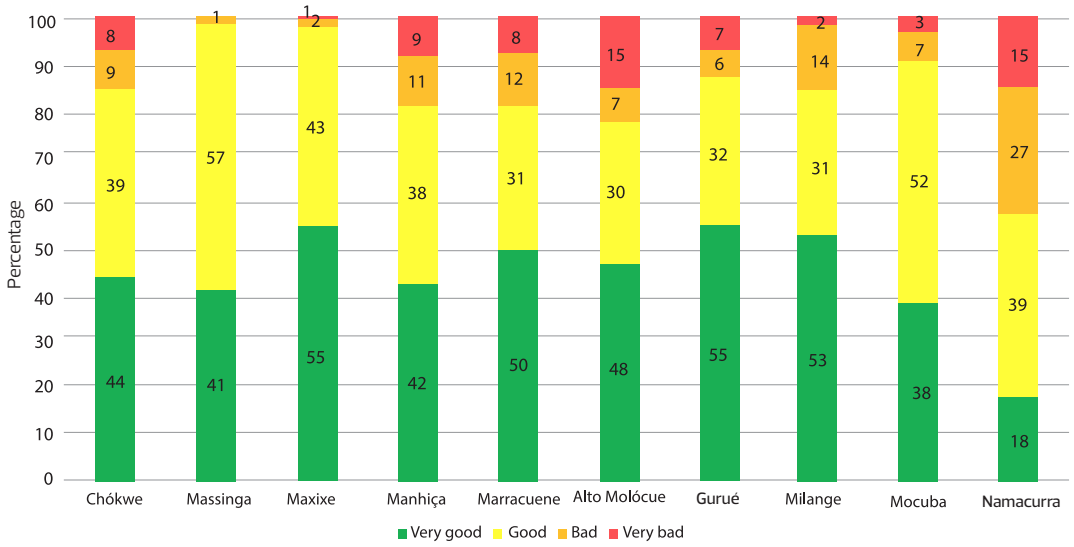
The poor results of Namacurra are due to some health care users, especially in Magubia and Malei HFs, complaining that services are offered first to acquaintances and, that for most of the time, the providers are engaged talking on the phone instead of giving their attention to the patients. The users of HFs in Maputo province made similar complaints. For example, the users of Manhiça's HFs mentioned the following challenges to the provision of quality services: (a) slow pace of services; (b) perception of users that some providers have discriminatory attitudes; (c) continuous change of providers that sometimes leads to discontinuity of follow-up of patients; (d) users jumping the queues and; (e) general use of technical language that is difficult for the patients to understand.

This dimension has two indicators: (i) the way the PLHIV are treated at the HF, and (ii) the level of knowledge about viral load.

The users of HFs in Maputo province made similar complaints. For example, the users of Manhiça's HFs mentioned the following challenges to the provision of quality services: (a) slow pace of services; (b) perception of users that some providers have discriminatory attitudes; (c) continuous change of providers that sometimes leads to discontinuity of follow-up of patients; (d) users jumping the queues and; (e) general use of technical language that is difficult for the patients to understand.

"They do not stand in the queue for the services. The acquaintances are attended to first, and those who arrive early are negatively affected." (Adult man living with HIV and on ART – HC Ilha Josina Machel, Manhiça district)

Chart 13: How do you evaluate the way you were treated at the HF?



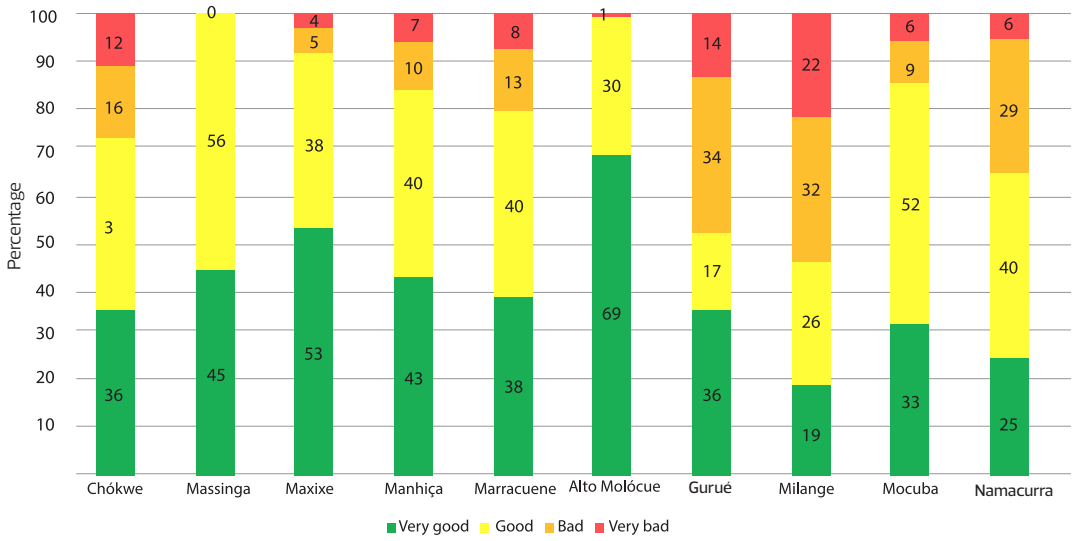
The results on the indicator regarding self-evaluation of the level of knowledge about viral load are presented in chart 14 below. Massinga ("Good" = 55% and "Very good" = 45%) and Alto Molócuè ("Good" = 30% and "Very good" = 69%) districts have the best results, followed by Maxixe ("Good" = 38% and "Very good" = 53%). High percentages among the health care users in the districts of Milange ("Bad" = 32% and "Very bad" = 22%), Gurué ("Bad" = 34% and "Very bad" = 14) and Namacurra ("Bad" = 29% and "Very bad" = 6%) evaluated their knowledge on viral load negatively.

The level of knowledge is related to the quality of information provided by the health providers. The users mentioned poor communication about viral load with the providers as a problem leading for them e.g. not to understand why they need to regularly monitor the viral load. The users also expressed concern regarding the delay in receiving the results of the viral load measurement – or not receiving them at all – as well as problems with registration of the results in the patients' files. The two quotations below describe these challenges:

"They take our blood for the analysis, but the results come back late, and even when the results are received, those are not registered in our files." (Adult man living with HIV and on ART – Gurué HC, Gurué district)

"...the counselors speak very fast so that we do not understand all the information that we are given." (Adult woman living with HIV and on ART – Mapapa-Chókwè HC, Chókwè district)

Chart 14: How do you evaluate the level of your knowledge about viral load?



The level of knowledge is related to the quality of information provided by the health providers. The users mentioned poor communication about viral load with the providers as a problem leading for them e.g. not to understand why they need to regularly monitor the viral load

4. A SUMMARY AT PROVINCIAL LEVEL[1] AND FINAL REMARKS

The analysis of the results of the first cycle of the CLM community consultation, aggregated by province, reveals that for the indicator about the hygiene in the consultation rooms for chronically ill patients (chart 15), Inhambane (''Good'' = 44% and ''Very good'' = 55%) has the best results, while the users in Zambézia (''Bad'' = 17% and ''Very bad'' = 9%) expressed most dissatisfaction about this component. Regarding privacy of the consultation rooms, there were many negative answers in all of the provinces, with Zambézia (''Bad'' = 29% and ''Very bad'' = 17%) again having the worst result, followed by Maputo (''Bad'' = 12% and ''Very bad'' = 8%), Gaza (''Bad'' = 10% and ''Very bad'' = 7%) and Inhambane (''Bad'' = 11% and ''Very bad'' = 6%). As already mentioned above, and similar to the results of previous CLM activities[2], these scores highlight the need to invest in HF infrastructures to guarantee privacy and separate spaces for different services. Similar to the previous indicators, Zambézia (''Bad'' = 15% and ''Very bad'' = 11%) has the worst results in terms of the quality of care provided by the health providers during the consultation for PLHIV, followed by Maputo province (''Bad'' = 13% and ''Very bad'' = 8%), while Inhambane province again has the best results with only 3% of users scoring this indicator as ''Bad'' or ''Very bad''.

In the indicator asking perceptions about the possibility for the entire family to receive ART at the same time (chart 15), the provinces of Gaza (''Bad'' = 20% and ''Very bad'' = 20%) and Zambézia (''Bad'' = 25% and ''Very bad'' = 18%) had the highest levels of negative answer. Inhambane (''Bad'' = 3% and ''Very bad'' = 2%) shows again the highest level of satisfaction with this approach. Similar results are seen in the indicator regarding the possibility to pick up ART without having to first attend a consultation. Gaza (''Bad'' = 20% and ''Very bad'' = 23%) and Zambézia (''Bad'' = 15% and ''Very bad'' = 10%) province again have the highest levels of dissatisfaction, while Inhambane province has the best results. The level of dissatisfaction with illicit charges is lower than in the other indicators discussed above.

The users' perception of the PSS services (chart 16) seems to be overall more positive than the perception of the ART services, discussed above. In all the three indicators of this component, Zambézia province again has the worst results, especially in the indicator regarding information provided about serostatus disclosure and the support from the family, community and other PLHIV (''Bad'' = 19% and ''Very bad'' = 9%). Similar to the ART services, health care users in Inhambane province seem to have the highest level of satisfaction with the quality of the PSS services.

In the two indicators related to the services at the pharmacy (chart 17), Maputo province has the worst results, followed by Zambézia. In the indicator related to the availability of ARV medicines at the pharmacy, in Maputo province 13% of the users

1. Charts provided in appendix 2

2. N'weti (2020[a] and 2020b) and N'weti (2021) [in press].

selected the answer "Bad" and 10% selected "Very bad", while in Zambézia province the corresponding figures were 8% and 5%, respectively. With the exception of Inhambane, all the other provinces had a considerable percentage of users who perceive that they are not treated well in the HF (chart 18). The results are similar for the indicator on self-evaluation on user knowledge on viral load. The users in Zambézia ("Bad" = 19% and "Very bad" = 10%) and in Gaza ("Bad" = 16% and "Very bad" = 12%) provinces evaluated their knowledge to be worse than users in Maputo and Inhambane provinces.

Overall, Inhambane province stands out for its excellent performance, while Zambézia has the worst results in many of the indicators. However, it is important to mention that all the scored HFs need interventions in at least one service covered by the indicators. Also, it should be noted that the first CLM cycle is considered a baseline, while comparisons can be made, and conclusions about quality drawn, only after the second cycle of CLM, to be initiated in July 2021. The results of the second cycle will be compared to those of the baseline (first cycle) to see if any changes have taken place between the cycles.

In between the first and second cycles of CLM, in order to improve the quality of the services, N'weti will ensure the integration of the interventions mentioned in the action plans created during the first cycle (annex 3) in the routine plans and activities of the clinical partner. The action plans will be monitored, and before the second cycle of CLM, joint monitoring visits will be undertaken together with the focal points of the clinical partners to evaluate the degree of accomplishment of the plans made for the improvement of quality of service delivery.

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APPENDICES

Appendix 1: Selected HFs for the CLM activity

Province	District	HF name	Province	District	HF name
Gaza	Chokwe	CS Cidade de Chokwé	Zambezia	Milange	CS Milange
		CS Chalucuane			CS Tengua
		CS Hokwe			CS Liciro
		CS Manjangue			CS Carico
		CS Lionde			CS Dachudua
		CS Chiaquelane Reassentamento			CS Dulanha
		CS 25 de Setembro			CS Chitambo
		PS Mapapa			CS Muanhambo
		PS Machua			CS Mongue
		CS Conhane			CS Grugunha
		PS Massavasse			CS Majaua
		CS Malhazine		Mocuba	HD Mocuba
		CS Muianga			CS 16 de Junho
		PS Cumba			CS Mugeba
		PS Chiaquelane			CS Pedreira
	Massinga	CS Cangela			CS Muanaco
		CS Chihunze			CS Namanjavira
	Maxixe	CS Manhala			CS Alto Benfica
		CS Bembe			CS Munhiba
Maputo	Manhiça	CS Maragra			CS Nhaluanda
		CS Maluana			CS Muaquiua
		CS Ilha Josina			CS Mocuba Sisal
		CS Malavela			CS Magogodo
		CS Taninga			CS Namabida
		CS Munguine			CS Mataia
		CS Calanga			CS Muloe
		CS Chibucutso			CS Chimbua
		CS Chichongue			CS Namagoa
		CS Magaba			CS Caiave
		CS Mirona		Namacurra	CS Muceliua
	Marracuene	CS Michafutene			CS Malei
		CS Machubo			CS Mugubia
Zambezia	Alto Molocue	CS Bonifacio Groveta			CS Muebele
		CS Nauela			PS Mutange
	Gurue	CS Gurue			CS Macuse
		CS Lioma			PS Furquia
					CS Namacurra sede
					CS Mexixine
					CS Mbawa

Appendix 2: Charts showing the aggregated provincial results

Chart 15: User's perception of ART services

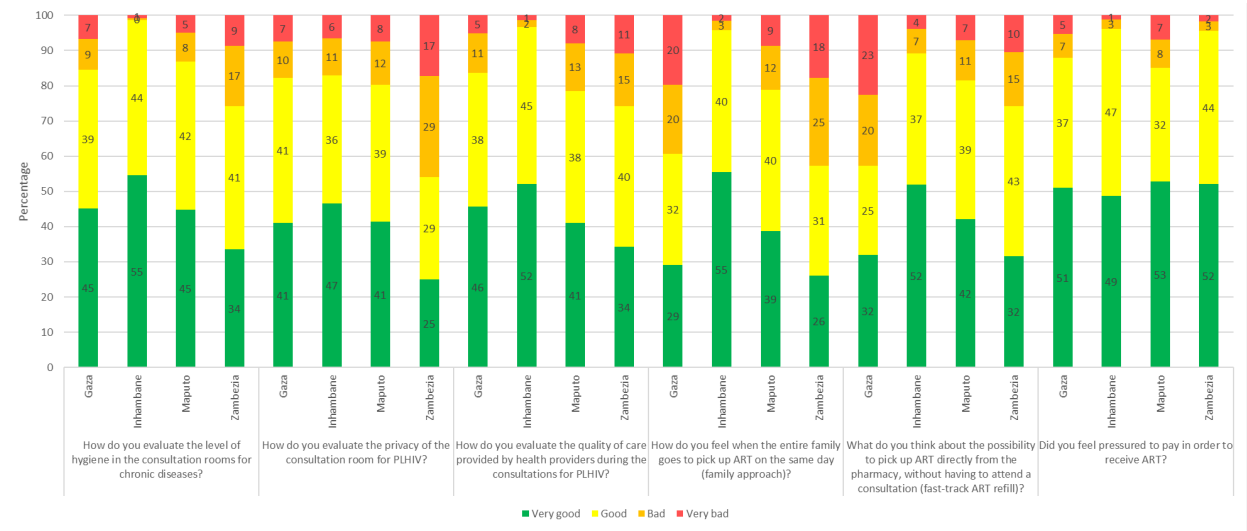


Chart 16: User's perception of the PSS services

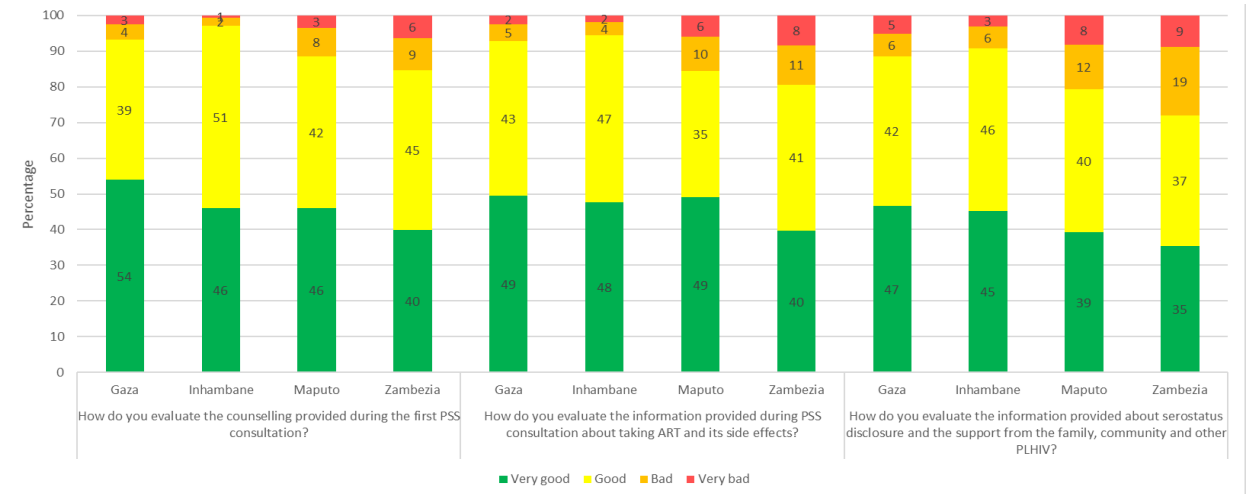


Chart 17: User's perception of the services provided in the pharmacy

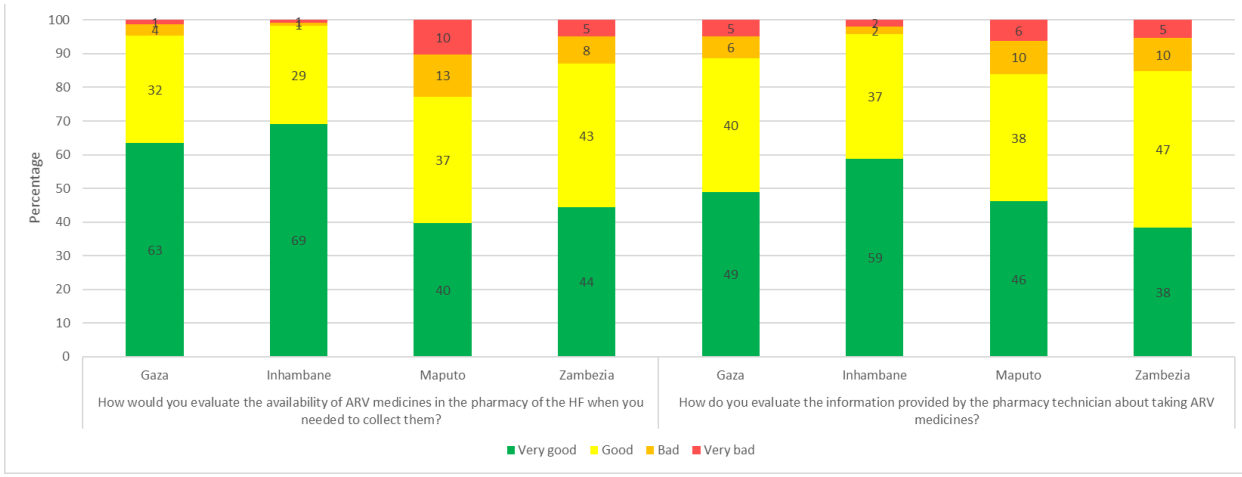


Chart 18: User's perception of the rights of PLHIV-How do you evaluate the way you were treated at the HF?

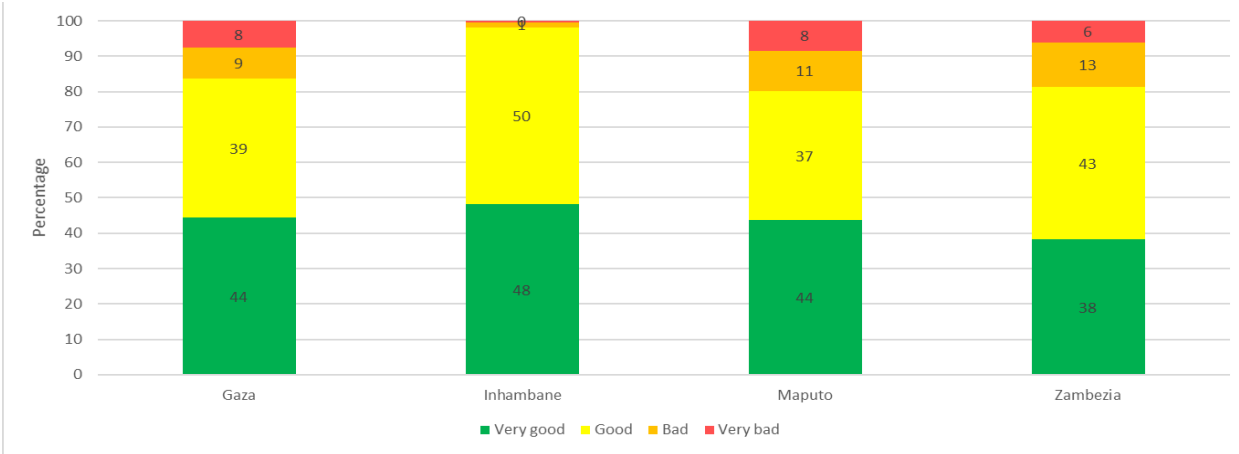
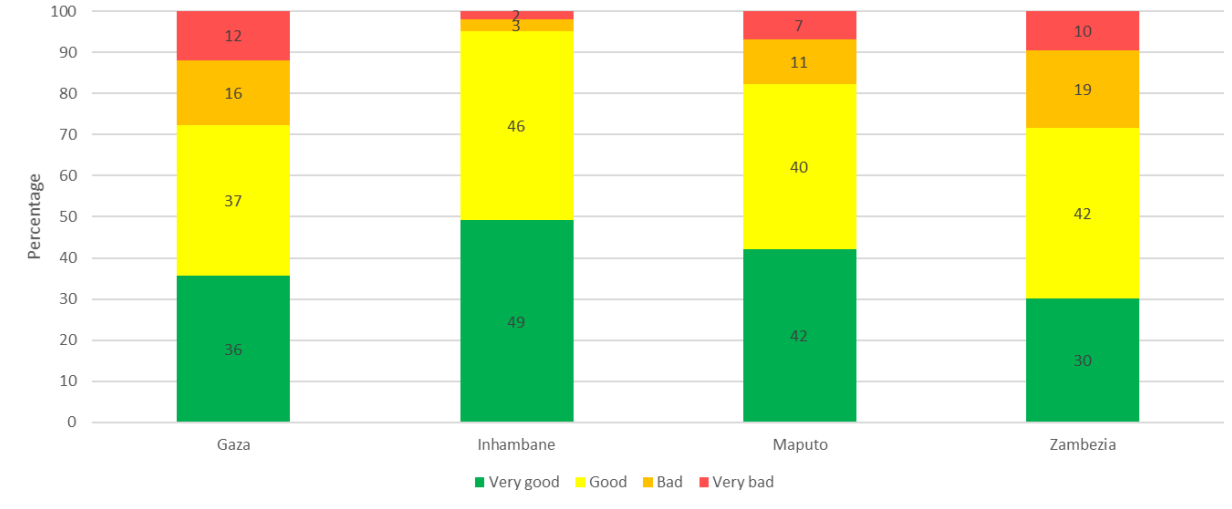


Chart 19: User's knowledge – How do you evaluate the level of your knowledge about viral load?



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